STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085039	A. BUILDING _____ B. WING _____	C 03/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW CASTLE HEALTH AND REHABILITATION CENTER	32 BUENA VISTA DRIVE NEW CASTLE, DE 19720

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced complaint investigation survey was conducted at this facility from March 6, 2018 through March 14, 2018. The facility census on the first day was 107. The survey sample included 15 residents. Abbreviations/definitions used in this report are as follows: NHA- Nursing Home Administrator; RNC - Regional Nurse Consultant; DON- Director of Nursing; DOR - Director of Rehabilitation; ADON-Assistant Director of Nursing; MD - Medical Doctor; NP - Nurse Practitioner; DOM -Director of Maintenance; RD - Registered Dietician; RM - Risk Manager; RN - Registered Nurse; RVP - Regional Vice President; LPN - Licensed Practical Nurse; UM - Unit Manager; OT - Occupational Therapist; COTA - Certified Occupational Therapy Assistant; CNA - Certified Nurse's Aide; CRD - Clinical Reimbursement Director; CRS - Clinical Reimbursement Specialist; Anal - involving, relating to, or situated near the anus; Anus - the external opening of the rectum; Aseptic - free from contamination caused by harmful bacteria, viruses, or other microorganisms; Alzheimer's dementia - A type of dementia which includes impaired thinking and memory;	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/26/2018

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 Braden scale - test used to determine risk for developing pressure ulcers; Central venous access devices (CVAD) - small, flexible tubes placed in large veins for people who require frequent access to the bloodstream; Coumadin - medication that is used as an anticoagulant/blood thinner; Cognitively Impaired - abnormal mental processes; thinking OR mental decline including losing the ability to understand, the ability to talk or write, resulting in the inability to live independently; Cognitive-process of knowing and understanding; Contact Isolation - precautions used for infectious diseases that are spread by touching the contaminated area; ER - Emergency Room; Extensive Assistance - While the resident performed part of the activity over the last 7 day period, help of the following type was provided 3 or more times: weight bearing support; full staff performance during part (but not all) of the last 7 days; OR resident involved in activity, staff provide weight-bearing support; Fall mat - device to reduce fall related injury; G tube - gastrostomy tube/tube inserted into stomach through the abdomen to provide feedings and medications; House barrier lotion - help protect the skin from excess contact with moisture and especially useful for those who wear protective underwear where feces or urine will come in contact with the skin for a length of time; Heel protector - device which lift the heel off of the mattress, minimizing pressure on the heel; Hoyer lift - A lift device to transfer an individual from one surface to another, such as from a bed to a chair; Hydrocolloid -a substance which forms a gel in	F 000		

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F 000	Continued From page 2	F 000		

the presence of water;
Hydrogel - a gel in which the liquid component is water;
Hydrogen peroxide - a liquid chemical used for killing bacteria;
Incontinence/incontinent - lack of bowel and/or bladder control;
Indwelling suprapubic urinary catheter - a tube that carries urine from the bladder to the outside of the body;
INR - International Normalized Ratio/measures how long it takes the blood to clot;
IV - intravenous/into a vein;
Lateral support - physical support to prevent sideways movement;
Malnutrition - a condition that results from eating a diet in which nutrients are either not enough or are too much such that the diet causes health problems;
MAR - Medication Administration Record;
Medihoney - treatment for a PU;
MDS - Minimum Data Set (standardized assessment forms) used in nursing homes;
Multiple Sclerosis - degenerative process of the central nervous system;
Neurological assessment - An assessment to check on the status of the body's nervous system including level of responsiveness and movements; of the central nervous system that mainly affects the motor systems (how one moves);
NS/NSS - Normal Saline/Normal Saline Solution - a 0.9% sterile solution of sodium chloride in water;
Physician Order Sheet (POS) - monthly report of active physician orders;
Parenteral - an IV (intravenous - into a vein) infusion of various solutions to maintain adequate hydration, restore and/or maintain fluid volume,

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F 000	Continued From page 3 reestablish lost electrolytes (minerals in the body) or provide partial nutrition; Perineal care - cleansing of area between the thighs, external genitals and anus; PICC - Peripherally Inserted Central Catheter/a thin, soft, long tube that is inserted into a vein in the arm, leg or neck and used for long-term intravenous (IV) antibiotics, nutrition or medications; Pressure Ulcer (PU) - sore area of skin that develops when the blood supply to it is cut off due to pressure; PU Stages: - Stage I (1) - Intact skin with a localized area of non-blanchable erythema, in which the redness on the skin, when pressed does not go away; - Stage II (2) - blister or shallow open sore with red/pink color; - Stage III (3) - open sore that goes into the tissue under below the skin. How deep it is depends on the amount of tissue under the skin; - Unstageable - actual depth of the ulcer cannot be determined due to the presence of slough (yellow, tan, gray, green or brown soft dead tissue) and/or eschar or necrotic (hard dead tissue that is tan, brown or black). Eschar or necrotic is worse than slough; -Deep Tissue Injury (DTI) purple or maroon intact skin or blood filled blister; -Suspected Deep Tissue Injury (SDTI); PU characteristics: - Undermining - skin edges have lost contact with underlying tissue; - Tunneling - A wound having a small entrance and exit of uniform diameter; - Peri-wound - bottom of a wound; - Granulation tissue - new tissue and small blood vessels that form on the surfaces of a wound during the healing process;	F 000		

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F 000	Continued From page 4	F 000		

PRN - as needed;
Protein Calorie Malnutrition - a form of malnutrition where there is inadequate calorie or protein intake (a nutrient essential to building muscle mass, commonly found in animal products);
Rectum -the concluding part of the large intestine that terminates in the anus;
Replicare - a hydrocolloid dressing;
Sacrum - a triangular bone at base of spine;
Skin prep no sting - a liquid film-forming dressing that, upon application to intact skin, forms a protective film;
STAT - with no delay; at once;
Severe Cognitive Impairment - unable to make own decisions;
Total assistance - Resident unable to perform the activity and required total assistance of staff to perform the activity;
TPN - Total Parenteral Nutrition/a form of feeding in which all nutritional needs are met with a solution which is infused into the veins;
T & R - Turn and Repositioning or Reposition;
Trochanter - area of thigh bone connecting to hip bone;
Urethra - the duct by which urine is conveyed out of the body from the bladder;
Urinary tract infection (UTI) - when bacteria gets into your urine and travels up to your bladder and causes an infection;
Vicair Cushion - a cushion which provides combination of optimal pressure redistribution and a stable positioning;
WCC (Wound Care Center) - facility that specializes in treatment of wounds;
WCD (Wound Care Documentation) - assessment of the wound;
BID or bid - twice a day;
cm (Centimeter) - a measurement, 1 centimeter

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F 000	Continued From page 5 = 0.39 inches or metric measurement of length; e.g. (exempli gratia) - means "for example"; i.e. - that is; @ - at; L - length; W - width; D - depth; < - less than; % - percentage; x - times; ml - milliliter; a liquid measure equivalent to 0.03 fluid ounces;	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that one (R11) of 15 sampled residents was free from neglect. Findings include: Cross refer F610, example 2.	F 600	1. Assurance of freedom of Neglect has been addressed by providing goods and services to R#11 necessary to promote healing to a Pressure Ulcer and to prevent new skin issues. R#11 was seen by the wound consultant and a more appropriate	5/14/18

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F 600	Continued From page 6 Cross refer F686, example 3. Review of R11's clinical record revealed the following: 12/27/17 - The quarterly MDS assessment stated that R11's daily decision making skills were independent and that she required total assistance of staff for transfers and extensive assist of two (2) staff for bed mobility and toilet use. Additionally, R11 did not have a pressure ulcer (PU), however, she was at risk for the development of a PU. 2/17/18 - Event Report, initiated by E14 (LPN), stated that R11 had a new PU on the right buttock which was identified on 2/17/18. This report was reviewed by E9 (Risk Manager), however, the facility failed to identify this as an allegation of neglect. 3/2/18 - State Agency's Incident Report documentation revealed on 3/2/18 at 3:00 PM, that the facility reported an allegation of neglect verbalized by R11 earlier on the same date at 9:00 AM. R11 expressed to facility staff that she felt she could not get out of bed because there were not enough staff present. Additionally, R11 alleged that the wound she was receiving treatment for was the result of staff not addressing her needs quickly enough. The facility failed to provide goods and services to R11 to avoid physical harm, as evidenced by the development of an avoidable PU and worsening of the PU from stage 2 to the development of slough, likely a stage 3. 3/14/18 approximately 4:30 PM - Findings were	F 600	treatment order was initiated. The care plan and CNA Kardex were updated to improve off-loading pressure to the affected area. 2. Facility reviewed and analyzed existing resident concerns, grievances, and event reports completed for all unplanned clinical outcomes such as new pressure ulcers for past 30 days to ensure any and all allegations of neglect of care have been identified, investigated and reported. 3. Root Cause Analysis revealed staff failed to identify and report an allegation of neglect in a resident grievance report. All concerns/grievance/event reports are now reviewed by the leadership team daily and shift supervisors on off shifts and weekends in conjunction with the NHA, DON and Risk Manager to assure adherence with the facility policy and procedures. The policy and procedure related to Event Reporting and Abuse, Neglect, Exploitation, Mistreatment of Resident or Misappropriation of Resident Property Policy and Event Reporting has been reviewed it was found to be proficient with no changes needed. Concerns/grievances/events are reviewed by the IDT team during the week day morning stand up meeting for identification of any allegations of neglect, abuse, or misappropriation and also by shift and weekend supervisors during the off shifts. Any allegation of abuse is	

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F 600	Continued From page 7 reviewed with E1 (NHA), E2 (DON), E3 (ADON), E15 (RNC) and E16 (RVP).	F 600	immediately investigated, addressed and reported. Nursing supervision has been increased by engaging three interim full time unit managers so that each unit has a manager to oversee the two units. One Unit Manager floats between the two to augment coverage. The Unit Managers and off shift supervisors are validating each shift that care and services are being provided to meet resident needs. The Unit Managers have been oriented and trained to oversee daily care. This includes performance of observational rounds to validate that care and services are being provided to residents to meet their needs. Two permanent Unit Managers will begin orientation on May 1, 2018 and will receive complete orientation before assuming the role. Nursing weekend and shift supervisors have been re-educated on reviewing, investigating and reporting of any concerns/grievances/events that may be identified as allegations of neglect, abuse, or misappropriation. A Huddle Form has been implemented to capture the specific care needs prioritizing unique care components, such as scheduled Skin Assessments, to be accomplished for each shift. (Attachment F600-1 Huddle Minutes form). Staff have been re-educated on the Abuse, Neglect, Exploitation, Mistreatment of Resident and	

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F 600	Continued From page 8	F 600	Misappropriation of Resident Property Policy. This education included how these are defined and how to recognize and report abuse, neglect, exploitation, mistreatment, and misappropriation of resident property. 4. Weekly audits of all grievances and concerns will be completed until 100% compliance with reporting allegations of abuse or neglect for three consecutive weeks until substantial compliance is achieved. Any trends will be addressed daily and brought to the QAPI meeting for review. The Administrator and/or designee will be responsible for this corrective action.	
F 610 SS=E	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the	F 610		5/14/18

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F 610	Continued From page 9 incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on clinical record review, interview and review of facility documents as indicated, it was determined that for four (R7, R11, R1, and R9) out of 15 residents sampled, the facility failed in response to allegations of abuse or neglect, to have evidence that all alleged violations are thoroughly investigated, and that the results of all investigations are reported to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Findings include: 1. Review of R7's clinical record revealed the following: 2/26/18 - The quarterly MDS assessment stated that R7's daily decision making skills were independent and that she required extensive assist of two (2) staff for bed mobility, transfer and toilet use. Review of a facility Event Report revealed that on 2/25/18 at 4:00 PM, R7 alleged neglect of care to the nurse manager on duty (E7). R7 alleged that E19 (CNA) had not provided incontinence care since 10:00 AM. Review of the facility's investigation revealed there were no statements included from E19 and E7. The facility failed to ensure that a thorough investigation of an allegation of neglect of care was conducted.	F 610	1. R# 7 was placed on a toileting schedule and the care plan and CNA Kardex were updated to reflect current needs. A thorough investigation of the above alleged issue for R#7 has been completed. Statements from E-7 & E-19 have been obtained. R# 11□s Care and services was provided as evidence by a wound consultant examination with necessary updates to the care plan and CNA Kardex to reflect current needs and interventions. A thorough investigation of the above alleged issue for R#11 has been completed and reported per state and federal regulations. R# 1□s mattress was changed to a bariatric mattress to increase room for repositioning. The fall mat is in place on the left side of the bed. The care plan and CNA Kardex were updated to reflect current interventions. A thorough investigation of the above alleged issue for R#1 has been completed. R#9 The event timeline was reviewed and revised to reflect the correct date and time. A thorough investigation of the alleged issue for R#9 has been completed. 2. Facility has reviewed the event reports for the past 30 days to ensure all	

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F 610	Continued From page 10 3/13/18 1:20 PM - Findings were reviewed with E9 (Risk Manager), who did not provide any additional documentation to the surveyor. 2. Cross refer F686, example 3. Review of R11's clinical record revealed the following: 12/27/17 - The quarterly MDS assessment stated that R11's daily decision making skills were independent and that she required total assistance of staff for transfer and extensive assist of two (2) staff for bed mobility and toilet use. Additionally, R11 did not have a pressure ulcer (PU), however, she was at risk for the development of a PU. 2/17/18 - Event Report, initiated by E14 (LPN) stated R11 had a new PU of the right buttock that was identified on 2/17/18. The documentation was reviewed by E9 (Risk Manager), however, the incident was not identified as an allegation of neglect and an investigation was not conducted by the facility. Additionally, there was lack of evidence that the NHA reviewed this incident. 3/2/18 - State Agency Incident Report stated on 3/2/18 at 9:00 AM, that R11 expressed to facility staff that she felt she could not get out of bed because there were not enough staff present. Additionally, R11 alleged that the wound she was receiving treatment for was the result of staff not addressing her needs quickly enough. 3/2/18 - Concern Report stated that R11 felt there was not enough staff to care for her needs and that staff told her they were short staffed.	F 610	investigations are complete and thorough and to determine if abuse, neglect, or misappropriation occurred. Investigations not complete or followed up within 5 days, were completed and reported as necessary. 3. A Root Cause Analysis revealed there was a deficient practice of recording and logging incident/event reports. In order to guide the flow of information and assure thorough and timely investigation and reporting: The facility now records the correct date and time of each incident on the event report and the Incident Report Check List (Attachment F 610-1 Incident Report Check List) to ensure that investigations are thorough, timely and complete; all events are recorded, logged and tracked on the Event Log (Attachment F 610-2 Event Log) which now includes tracking the 5 day follow up. The checklist requires the completion of steps to ensure all relevant information is gathered. Facility nursing leadership (DON, ADON, and Unit Managers including off shift and weekend nursing supervisors) have been educated on the newly developed incident report checklist and how to conduct a complete and thorough investigation of an incident and/or event, including timely reporting to the state agency. Staff nurses have been educated on the new checklist and how to complete a	

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F 610	Continued From page 11 Documentation included that E2 (DON) reviewed the last two weeks of the staffing schedule and stated at no time was there a staffing crisis on R11's wing. Record review lacked evidence that the facility established a system to ensure thorough investigation of an allegation of neglect for R11. 3/9/18 - At approximately 11:15 AM, an interview with E9 (Risk Manager) was conducted. E9 confirmed upon receiving the Event Report on 2/18/18, that he did not identify this as an allegation of neglect. Additionally, on 3/2/18, when R11 alleged the wound was the result of staff not addressing her needs quickly enough, E9 verbalized that the investigation was conducted by E2 (DON). 3/9/18 - At approximately 1:00 PM, interview with E2 revealed that she investigated the complaint and determined that staffing was sufficient to meet R11's needs, however, E2 did not investigate the allegation made by R11 that the new PU was a result of staff not addressing her needs quickly enough. No further investigative information was provided to the surveyor by the facility related to the allegation of neglect during the survey. 3. Review of R1's clinical record revealed the following: 8/20/15 - Care plan for fall/fall risk, with most recent revision date of 2/28/18, included an intervention for a fall mat to the left side of the bed.	F 610	thorough investigation including reporting to nursing leadership. The risk manager will provide an updated tracking log (F610-2) to the Administrator on a daily basis during the week to manage this process. 4. Weekly audits of all incidents/events for timely reporting, thorough investigations and 5 day follow will be completed until 100% compliance for three consecutive weeks until substantial compliance is achieved. Any trends will be addressed daily and brought to the QAPI meeting for review. The Administrator and/or designee will be responsible for this corrective action.	

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NEW CASTLE HEALTH AND REHABILITATION CENTER	32 BUENA VISTA DRIVE NEW CASTLE, DE 19720

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F 610	Continued From page 12 2/28/18 - Event Report documented an allegation of neglect in which R1 had an unwitnessed fall from the bed to the floor, in his room. R1 was noted with scratches on his right knee after the fall. Record review lacked evidence of a thorough investigation since there was no determination which side of the bed R1 fell from and R1 was care planned to have a fall mat to the left side of the bed to minimize injury from a fall. 3/13/18 at 1:20 PM - Findings were confirmed for lack of a thorough investigation with E9 (Risk Manager). 4. Review of R9's clinical record revealed the following: 2/11/18 - Event Report documented an allegations of verbal abuse and neglect which occurred during the 11:00 PM - 7:00 AM shift. The accused was identified as E11 (LPN). The facility's investigation revealed that E11 was interviewed and allegations were unsubstantiated. 2/14/18 - State Agency Incident Report stated R9 expressed an allegations of verbal abuse and neglect by a nurse on 2/11/18. 2/22/18 - State Agency Incident Report stated the facility investigation unsubstantiated the allegations. 3/13/18 at approximately 2:00 PM - An interview with E29 (SW) who obtained the complaint from R9 on 2/14/18 revealed that it was her understanding that the incident occurred on 2/12/18 during the evening shift, 3:00 PM - 11:00	F 610		

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F 610	Continued From page 13 PM. 3/13/18 at 1:20 PM - An interview with E9 confirmed that he failed to acertain the correct date of the incident. . The facility failed to ascertain the correct date and time of the incident, thus, failed to thoroughly investigate the allegations. In addition, the facility failed to ensure timely investigation and follow-up with the State Agency. 3/14/18 approximately 4:30 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E15 (RNC) and E16 (RVP).	F 610		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.	F 657		5/14/18

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F 657	Continued From page 14 (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to invite one (R8) out of 15 sampled residents to a care plan meeting. Additionally, the facility failed to review and revise care plans for two (R10 and R11) out of 15 sampled residents: Findings include: The facility's policy and procedure titled Care Plan, undated, stated, 7. Care Plan Meeting Invitation 7.2 The Clinical Reimbursement Director (CRD) and/or Clinical Reimbursement Specialist (CRS) facilitates the care plan schedules and letters to be delivered to the Resident or their Representative prior to the care plan meeting date 7.2.1 A copy of the letter is retained by the facility and should be filed into the medical record upon completion of the care plan meeting. 1. Review of R8's record revealed: 11/28/17 - Admitted to the facility from the hospital. 12/18/17 - Comprehensive care plans completed. Record review lacked evidence that R8 received a letter prior to the care plan meeting and that R8 attended this meeting.	F 657	1. R#8 was invited although not timely and attended his quarterly care plan meeting on March 6, 2018. R#10: This resident no longer resides in the facility and was discharged March 16, 2018. R # 11□s care plan and CNA Kardex related to wounds have been reviewed and revised to reflect the current interventions. 2. The clinical records for all new admissions in the past 30 days have been audited to assure that proper invitation to the initial care plan meeting has occurred and that the meetings are performed timely according to the requirements. The Clinical Reimbursement team completed a comprehensive review of all resident care needs and updated the care plans and CNA Kardex to reflect current interventions. This was performed in collaboration with other clinical disciplines. 3. A Root Cause Analysis revealed the Clinical Reimbursement Team overlooked inviting R#8 to participate in the initial care	

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F 657	Continued From page 15 3/8/18 at approximately 9:30 AM - An interview with R8 revealed that his first care plan meeting was on 3/6/18 and R8 indicated he did not receive a letter related to this meeting, however, he was informed shortly before the meeting on the same date, 3/6/18. 3/8/18 at approximately 11:30 AM - An interview with E7 (CRS) confirmed that R8 was not invited to the initial care plan meeting and the first care plan meeting attended by R8 was on 3/6/18. The surveyor requested for a letter forwarded to R8 related to the care plan meeting held on 3/6/18, however, no evidence was provided during the survey. 2. Cross refer F686, example 3. Review of R11's clinical record revealed: 9/28/17 - Admitted to the facility with diagnoses including multiple sclerosis. 9/28/17 - Admission orders included T & R every 2 hours every shift, house barrier lotion to perineal area each shift, may keep at beside, CNA may apply, weekly skin assessment, Braden Scale on admission and weekly for 4 weeks, Skin Prep no sting apply to bilateral heels (no specific shift identified). 9/28/17 - A plan of care for wounds and at risk for wounds, with an initial date of 9/28/17 and the most recent review date of 12/24/17, documented that R11 was at risk due to moisture from incontinence. The goal was that R11 would not develop a wound. Interventions included: - Treatment as ordered.	F 657	plan meeting and a deficient practice of the nursing team in following up on necessary updates to care plans. All future resident scheduled care conference has been reviewed by the clinical reimbursement director (CRD) for timeliness and notifications. This is performed using the PCC scheduling system. This schedule is reviewed weekly. Timely notification to allow adequate planning to attend the meeting to the resident and responsible party is occurring based on the above schedule. Care plans and CNA Kardexes are now reviewed and revised in the daily clinical meeting by the interdisciplinary team. Nurses not following our policy for this have been re-educated on the expectation to perform this task. Nurses on each unit have been educated to update the care plan and CNA Kardex for intermediate interventions until the interdisciplinary care team meets in the weekday clinical meeting. F657-1 is an example of an invitational letter to responsible party/family with an option to have telephonic participation. The clinical reimbursement team has been in-serviced to assure that the policy on resident participation in care planning process is occurring. 4. Weekly audits of care plans and CNA Kardex will be completed until 100%	

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F 657	Continued From page 16 - T & R every (frequency of this intervention was not documented) - Support surface to bed-Low air loss air mattress. - Support surface to chair-wheelchair cushion. - Float heels when in bed. 2/17/18 and timed 6:00 PM - Progress Note, by E14 (LPN) documented new PU of right inner buttock. 2/17/18 - Weekly Pressure Ulcer Assessment documented a new stage 2 PU of right lower buttock. Although R11 had a new stage 2 PU of right buttock, record review lacked evidence that the care plan for wounds was reviewed and revised. 2/28/18 - Order for R11 was to be out of bed for only two hours every day until the wound was healed. Again, review of the care plan for wounds lacked evidence that the facility had a system in place to incorporate this new intervention. 3/6/18 at approximately 3:16 PM - An interview with E6 (RN, UM North Unit) confirmed the care plan for wounds was not revised to include the actual PU of the right buttock. Additionally, the care plan failed to include the frequency of T & R and the weekly skin assessment by a licensed nurse. Although the facility had a Wound Care Team to oversee wounds in the facility, record review and interview lacked evidence that the facility had a system to review and revise the interventions on	F 657	compliance is achieved for three consecutive weeks. Weekly audits of all care plan meetings will be completed until 100% compliance is achieved for three consecutive weeks. Any trends will be brought to the QAPI meeting for review. The DON and/or designee will be responsible for this corrective action.	

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F 657	Continued From page 17 R11's care plan for wounds. 3/14/18 - At approximately 1:30 PM, the surveyor requested a copy of the care plan for wounds from E6. The documentation was updated during the survey to include the new interventions to T & R every 2 hours, to be out of bed for a maximum of 2 hours per day, and weekly skin assessments. 3. Cross refer to F686, example 1. Review of R10's clinical record revealed: 1/12/18 - A care plan included a problem for wounds and at risk for wounds with the goal to was to prevent wounds from developing, promote wound healing, treat wound infection and prevent additional wounds was initiated for R10. 2/1/18 - A physicians order was written for an antibiotic for 10 days. 2/2/18 - Lab results of wound culture identified the presence of three infectious causing organisms. 2/5/18 - A care plan problem for infections was initiated for R10 that documented an infection, location "suspected wound". 2/6/18 - A physicians order documented a wound care referral for sacral wound, and to discontinue the previous antibiotic for a different antibiotic, and contact isolation. R10's care plan for wounds was not updated to reflect contact precautions related to an infected wound.	F 657		

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F 657	Continued From page 18 During an interview on 3/9/18 at 1:13 PM with E3 (ADON) it was confirmed that R10's care plans for both wounds and for infections should have been updated to reflect the wound infection and contact precautions. 3/14/18 approximately 4:30 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E15 (RNC) and E16 (RVP).	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, interviews and review of other facility documentation, it was determined that for one (R10) out of 15 sampled residents, the facility failed to provide services that met professional standards of quality during incontinence/perineal care. Findings include: Cross refer to F686 Example 1; Current professional standards for providing perineal/incontinence care according to Lippincott manual of Nursing Practice 10th ed. (2013) Lippincott Williams and Wilkins indicated the following: "Using a washcloth and warm water, gently clean the skin of the perineal area moving from front to back. Do not move from back to front due to the risk of introducing germs from the anal area into	F 658	1. R# 10 no longer resides in the facility. This resident was discharged on March 16, 2018. Employee E21 has been re-educated on how to perform appropriate incontinent/perineal care on residents and has completed competencies with return demonstrations. 2. All residents have the potential to be affected by this deficient practice. 3. A Root Cause Analysis revealed a deficient practice of nursing staff performing incontinent/perineal care. CNAs have been re-educated on how to perform appropriate incontinent/perineal	5/14/18

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F 658	Continued From page 19 the urethra, a primary source of urinary tract infection. Use a clean area of washcloth each time for each peri-area." During a dressing change observation on 3/8/18 at 10:45 AM with E21 (CNA), R10 was visibly soiled from being incontinent of urine. E21 was observed wiping R10's perineal area three times from back to front also used the same wash cloth and did not fold the wash cloth to use a different area. During an interview immediately following the dressing change observation, at 11:03 AM E21 confirmed the direction of wiping during incontinent care for R10. 3/14/18 approximately 4:30 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E15 (RNC) and E16 (RVP).	F 658	care on residents and have completed competencies with return demonstrations. This was accomplished by the Staff Development Director. Daily nursing supervision is occurring to determine that care and services meet professional standards. 4. Audits, consisting of an observation of perineal/incontinent care by one aide on each unit (varying shifts), will be conducted weekly until 100% are in compliance, then for three consecutive weeks until substantial compliance is achieved. Any trends will be brought to the QAPI meeting for review. The DON or designee is responsible for this corrective action.	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based upon record reviews, staff interviews, and a review of other facility documentation, it was	F 684	1. R#1□s baseline neuro-check was completed and communicated to the	5/14/18

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F 684	Continued From page 20 determined that the facility failed to ensure one (R1) out of 15 sampled residents received treatment and care in accordance with professional standards of practice. R1 had an unwitnessed fall and the facility failed to complete neurological assessments. Findings include: Review of the facility's Clinical Guideline titled Neurological Evaluation stated neurological assessment will be completed when a resident has experienced a change in level of consciousness, after a fall with a known head injury or after an unwitnessed fall. Review of R1's clinical record revealed: 1/29/18 and timed 7:00 AM - Progress note documented R1 had an unwitnessed fall from the bed and was found on the fall mat. R1 was assessed and no apparent injury noted. Record lacked evidence of neurological assessment following an unwitnessed fall. 1/29/18 and timed 3:30 PM - Progress Note documented R1 with complaints of headache and medication given. 1/29/18 - Review of the Medication Administration Record documented the administration of medication for headache with positive results from the medication. 3/9/18 at approximately 1:00 PM - An interview with E9 (Risk Manager and Staff Educator) confirmed the facility failed to have evidence of neurological assessment when R1 had experienced an unwitnessed fall.	F 684	attending physician. 2. Those residents with an unwitnessed fall in the last week have been reviewed to ensure they have had neurological assessments. If neurological assessments were not performed, a neurological assessment was performed and any negative outcomes were communicated to the physician. 3. A Root Cause Analysis revealed clarification was needed on the Neurologic assessment policy to address its completion within 72 hours versus 72 times. The policy also needed clarification to include unwitnessed falls. The facility□s Clinical Guideline, titled Neurological Evaluation (Attachment F 684-1 Neurological Evaluation) has been reviewed and revised to clarify clinical monitoring. Nurses have been re-educated on performance expectations to meet professional standards. Nurses have been educated on the facility□s Clinical Guideline, titled Neurological Evaluation that describes that unwitnessed falls are reviewed with the nursing supervisor at the time of the event and that individual verifies that the neurological checks are started. This resident will be placed on the 24 hour report with the indication that neuro checks are being performed. This is reviewed in the clinical meeting and by the nursing supervisor during off shifts.	

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F 684	Continued From page 21 3/14/18 at approximately 4:30 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E15 (RNC) and E16 (RVP).	F 684	Residents who have an unwitnessed fall have neurological assessments performed according to the facility□s Clinical Guideline, titled Neurological Evaluation. 4. Weekly audits of all unwitnessed resident falls will be completed until 100% compliance of neurologic assessments for three consecutive weeks until substantial compliance is achieved.. Any trends will be brought to the QAPI meeting for review. The DON is responsible for this corrective action.	
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, interview, and review of other facility documentation as	F 686	1. R10 no longer resides at the facility. This resident was discharged March 16,	5/14/18

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F 686	Continued From page 22 indicated, it was determined that the facility failed to provide the necessary treatment and services, to promote healing of a pressure ulcer (PU) for three (R10, R12 and R11) out of 15 sampled residents. R10 developed an avoidable PU to the sacrum and failed to be provided the necessary treatment to promote healing of a pre-existing area to R10's right heel. R12's pressure ulcer worsened due to a failure to provide care and services to promote healing of a pressure ulcer. R11 developed an avoidable PU of the right buttock and the facility failed to establish individualized interventions for pressure reduction resulting in worsening of the PU. Findings include: The facility's policy entitled Wound Prevention and Treatment Overview, indicated: Prevention Protocols- was to assist clinicians to identify those who are at risk of skin breakdown by measuring key areas and other individualized factors that put the resident/patient at risk. Early identification will assist the facility in developing an individualized plan of care. Procedure: 1. The Braden scale will be completed within the first 8 hours of admission. 2. An initial care plan will be initiated by selecting the interventions to reduce risk. 3. The licensed staff will complete the weekly and as needed Skin Checks which may identify changes in resident that could trigger a change of condition or care plan review. 4. The resident will be monitored using the Braden Risk on a quarterly basis and PRN if there was a change in condition. Suggested interventions: Moderate Risk: For residents with Braden score of 14-18, the facility to select the appropriate	F 686	2018. R12 no longer resides at the facility. This resident expired on April 7, 2018. R11 On March 29, 2018, an IDC plan meeting was held with R11 and her brother to identify her preferences and clarify how care would be performed. The care plan and CNA Kardex were updated to reflect care preferences and goals for this resident. 2. All residents have been reassessed by an external wound care consultant (completed April 11, 2018) with our nursing team for skin integrity issues and skin breakdown to establish a new baseline. 3. A Root Cause Analysis revealed multiple areas of improvement opportunities. The facility implemented the following actions to address these findings: All resident Braden Scales have been reviewed. Based upon the Braden scale score, a specific care plan has been implemented to prevent or treat pressure ulcers and other skin integrity issues. All new admissions and readmissions had a skin integrity assessment completed to ensure identification of any skin breakdown. Any resident with skin breakdown found upon admission had their care plan and CNA Kardex updated to provide the necessary resident care.	

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F 686	Continued From page 23 following interventions: -Skin hygiene and inspection-Inspect the skin daily for early signs and symptoms of breakdown. -Activity/Mobility-Implement an individualized turning schedule if applicable to include observation of skin after each turning interval and increase frequency of turning if area of redness was noted. Position body with pillow or other supportive device. Avoid positioning on trochanter when possible. Provide pressure redistribution surface for bed or wheelchair per the facility's support surface selection. High Risk: For residents with a Braden score of 0-13, the facility to select the following interventions: -Skin hygiene and inspection-Inspect the skin daily for early signs and symptoms of breakdown. -Activity/Mobility-Implement an individualized turning schedule if applicable to include observation of skin after each turning interval and increase frequency of turning if area of redness was noted. Position body with pillow or other supportive device. Avoid positioning on trochanter when possible. Provide pressure redistribution surface for bed or wheelchair per the facility's support surface selection. -Skin protection - Use a sheet to reposition the resident in bed, protect heels as needed, apply Skin Prep for protection. -Nutrition - obtain dietary consult if deficiencies are noted. Evaluate interventions. 1. Review of R10's clinical record revealed the following; 1/10/18 - R10 was admitted to the facility with multiple diagnoses including Alzheimer's dementia and general muscle weakness.	F 686	Any identified skin integrity issues were addressed by nursing staff after obtaining physician orders. Care plans and CNA Kardexes have been reviewed and are now updated to reflect recommendations of the wound consultants and risk level determined by the Braden Scale. The following measures and/or systems changes have been made to prevent reoccurrence: The facility has engaged a wound care Nurse Practitioner, who on a weekly basis, assesses residents with current skin breakdown. In conjunction with facility personnel, they reassess effectiveness of current interventions. The facility has implemented a Weekly Skin Integrity and Nutrition Committee. This ID team committee ensures preventative measures are in place and a comprehensive plan of care promotes positive outcomes. The facility Treatment Guidelines for Wound Care has been reviewed to ensure that it was inclusive of the following: Prevention (Turning and Reposition) Internal weekly skin checks; and Provision of support services (Cushions).	

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F 686	Continued From page 24 1/10/18 - An initial weekly skin assessment form documented R10 as having bruising on the "heel" measuring 3.5 cm x 1.9 cm; which heel, right or left, was not documented. 1/10/18 - Admission assessment documented R10's Braden score as "11" (0-13 is high risk), current skin condition PU, discoloration, bruises and "scab" right calf and a circle drawn over right heel with no description. Additional skin impairment risk factors documented were short term memory loss and incontinence of bowel and bladder. The following were "checked" under the Braden risk score: therapy screen for cushion, position with support devices, float heels, turn and reposition, pressure relieving mattress, barrier cream if incontinent. 1/10/18 - Admitting orders for PU documented on the POS included house barrier lotion to perineal area each shift; may keep at bedside; CNA may apply; weekly skin assessment on Wednesday; Braden Scale on admission and weekly for 4 weeks; Skin Prep no sting apply to bilateral heels every evening; in house wound care consult as needed; apply heel protectors to both feet every shift. 1/10/18 - The CNA care plan documented R10 as dependent for turning and repositioning and to be turned and repositioned as needed. 1/10/18 4:00 PM - A nurses note documented R10 as having "maroon colored discoloration" to the right heel. 1/11/18 - WCD documented a stage 1 to the right heel 3.5 cm x 1.9 cm x 0 with pink red shiny moist granular appearance skin. Note the presence of	F 686	Staff have been re-educated on the following: Nurses: Facility Treatment Guidelines for Wound Care; Nurses and CNAs: Individualized resident centered turning and repositioning program; Nurses: The necessary components of all physician orders; inclusive of wound treatments Nurses: Wound staging, proper treatment and prevention strategies (provided by consultants); Nurses and CNAs: Internal Weekly Skin Checks; and Physical and Occupational Therapy: Positioning devices CNAs have been re-educated to report any observed skin abnormality to the nurse. Resident turning and positioning schedule is specific to each resident and is indicated on the CNA Kardex and is documented in the PCC point of care documentation. Skin checks are performed at least weekly to assure timely identification of new wounds or skin integrity issues on each resident to develop interventions and	

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F 686	Continued From page 25 granular tissues indicates the wound was not a Stage 1. 1/12/18 - A care plan for wounds and at risk for wounds was initiated. The goal was to prevent wounds from developing, promote wound healing, treat wound infection and prevent additional wounds. Interventions included: - Treatment as ordered. - Monitor vital signs. - Support surface to bed. - Float heels with heel protectors. - Monitor sacrum daily. 1/17/17 - WCD documented a DTI right heel 3.5 cm x 1.5 cm x 0 with necrotic skin. 1/17/17 - An admission MDS assessment documented R10 as severely cognitively impaired; requiring extensive assistance of two staff persons for bed mobility and toileting; incontinent of bowel and urine. R10 had one SDTI and was at risk for developing PU. Treatments included pressure reducing device for chair and bed, turn and repositioning program, PU care, and applications of ointments. 1/26/18 - WCD documented a DTI measuring 3 cm x 9 cm x 0 having necrotic skin to the gluteal area. 1/27/18 - WCD documented to the right buttock a stage 2 PU measuring 0.4 cm x 0.4 cm x 0 having new skin /superficial ulcer that was not present on admission. 1/27/18 - WCD documented to the right buttock a second area above the other right sided area as a stage 2 PU measuring 2.8 cm x 1.4 cm x 0.1 cm	F 686	treatment as needed. Daily rounds are completed by the Unit Managers, Nursing supervisors, and others to validate that care interventions are occurring and skin integrity is maintained where possible. 4. The following monitoring and Quality Assurance Performance Improve (QAPI) systems has been implemented to ensure ongoing compliance: Weekly audits of skin assessments are being performed by the external wound care consulting company (NP) to ensure follow through on recommendations weekly for four weeks, then monthly. These audits include: Skin check completion as required; Identified areas of concern are addressed per nursing standards of practice. Weekly Skin Check audits until 100% compliant for three weeks until substantial compliance is achieved. Audits will be conducted by the ADON or designee. Audits will be completed and/or continued until the facility consistently reaches 100% for 3 consecutive weekly evaluations, then randomly for 4 weeks. Any trending identified will be brought to	

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F 686	Continued From page 26 having new skin /superficial ulcer that was not present on admission. 1/27/18 - WCD documented to the left buttock a stage 2 PU measuring 3 cm x 5 cm x 0.1 cm having new skin /superficial ulcer that was not present on admission and identified 1/26/18. 1/28/18 - Treatment orders were initiated for R10's sacrum. 1/29/18 - A physicians order was written for a wound culture during dressing change, wound location was not specified in the order. 1/29/18 - R10's treatment order to the sacrum was changed. 1/31/18 WCD documented both areas to the right buttock, the area to the left buttock and the area to the gluteus as "merged to one" area, DTI 10 cm x 8.2 cm x 0, no undermining, with necrotic skin. January 2018 - Review of CNA documentation for turning and repositioning revealed 20 dates from 1/10/18 -1/31/18 that lacked documentation that R10 was turned each shift. 1/10- 2/9/18 - Monthly Functional Care Summary documented R10 had a "heel and sacrum DTI antibiotic in progress for wound." 2/1/18 - A physicians order was written for a dietary consultation related to "increase protein needs for wound healing". 2/1/18 - A physicians order was written for an antibiotic for 10 days for suspected wound	F 686	the monthly QAPI Committee. The DON and /or designee are responsible for these corrective actions.	

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F 686	Continued From page 27 infection. 2/2/18 - Lab results of wound culture identified the presence of three infectious organisms. 2/5/18 - A care plan for infections was initiated for R10 that documented a bacterial infection location "suspected wound", with the goal to treat the current infection x 14 days or until resolved, manage signs and symptoms for ten days or until resolved. Interventions did not include contact precautions but did include: - Monitor temperature. - Monitor labs. - Administer medications. - Monitor daily appearance of infected site, if visual. - Document administration of medications and route of administration. - Monitor for SE [side effects] and monitor for presence or absence of pain. 2/5/18 - A dietary recommendation was written for liquid protein 30 ml BID record % consumed. 2/6/18 - A physicians order documented a referral to a WCC for sacral wound, and to discontinue the previous antibiotic for a different antibiotic, and contact isolation. 2/11/18 - R10's care plan for wounds was updated to include a pressure reducing air mattress. 2/13/18 - A physicians order was written for narcotic (stronger than over the counter) pain medication every 4 hours PRN for severe pain prior to dressing changes.	F 686		

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F 686	Continued From page 28 2/13/18 - WCD documented to the gluteal a DTI 6 cm x 6.6 cm x 2 cm with undermining and slough in wound. 2/15/18- A physicians order was written for changes to the treatments for R10's sacrum and right heel and to continue to turn and reposition every 2 hours, carefully apply cushion when sitting in chair and return to wound center on 2/28/18. 2/20/18 - A physician's order was written for liquid protein supplement 30 ml BID and record amount consumed. This physician's order was written 15 days following the initial documented recommendation by E20 (RD). 2/25/18 - The Braden score documented "12" high risk. 2/26/18 - A consultation note from the WCC documented to continue to offload with supportive mattress, frequent turns and add waffle boot. February 2018 - Review of CNA documentation for turning and repositioning revealed 17 dates out of 28 days that lacked documentation that R10 was turned each shift. 3/5/18 - A consultation from the WCC documented continue to offload sacrum, side sleeping please, protect right heel for pressure from chairs. 3/6/18 - WCD documented to the gluteal area measuring 5.3 cm x 3.8 cm x 2.0 cm with undermining 2.5 cm and slough. March 2018 - Review of CNA documentation for	F 686		

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F 686	Continued From page 29 turning and repositioning revealed 9 dates from 3/1/18 -3/13/18 that lacked documentation that R10 was turned each shift. During an interview on 3/9/18 at 1:13 PM with E3 (ADON) it was confirmed that R10 developed an avoidable pressure ulcer to the sacrum and experienced worsening of a pressure area to the right heel and that implementation of nutritional recommendations to assist in promoting wound healing were implemented 15 days after the recommendation and the expected time frame for implementation was "24 hours". R10 was admitted with an area of discoloration to the right heel and an intact sacral area. Initial orders included the intervention of turning and repositioning each shift but CNA documentation lacked evidence that R10 was turned at that frequency. Dietary supplements recommended for wound healing were not implemented until 15 days following the recommendation. 2. Review of R12's clinical record revealed the following; 1/29/18 - R12 was admitted to the facility. 1/29/18 - Admitting orders for PU documented on the POS included turn and reposition, skin prep to bilateral heels every evening, barrier cream to peri-area every shift, air mattress, weekly skin assessments, and Braden Scale on admission and weekly for four weeks. 1/29/18 - An admission assessment completed for R12 was absent a Braden Scale and documented skin as cool, dry, moist and a "bruise" to the right arm.	F 686		

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F 686	Continued From page 30 1/29/18 - A care plan problem was initiated for a wound to sacrum and risk of PU with "...contributing factor, pressure and a goal to prevent wounds, promote healing, prevent infection treat wound infection" and included interventions: - Monitor vital signs. - RD consult PRN. - Monitor labs as ordered. - Standard Precautions. - Support surface to bed and chair, type: pressure reducing. - Float heels with heel protectors. - Air mattress - Monitor daily: wound location, dressing observation. Monitor weekly location, stage, length, drainage, odor, tunneling, undermining. 1/29/18 9:45 PM - A nurses note documented R12 as having "redness noted to buttocks area." 1/29/18 - a physician's order was written for R12 "turn and reposition every 2 hours." January 2018 - Review of R12's TAR was absent documentation that indicated an admission Braden Scale was completed. January 2018 - Review of CNA documentation for turning and repositioning each shift revealed 3 out of 3 dates from 1/29/18-1/31/18 that lacked documentation that R12 was turned each shift. 2/2/18 - An admission MDS assessment documented R12 as severely cognitively impaired with risk of developing a PU and requiring extensive assistance with bed mobility, toileting and was incontinent of bowel and urine. R12 had	F 686		

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F 686	Continued From page 31 a risk of developing a PU and treatments included a pressure reducing device for bed and chair. 2/5/18 - The first documented Braden scale for R12 was "11" high risk. 2/12/18 - An initial wound identification form documented R12 as having a "SDTI, Stage 1 discolored skin dark purple measuring 1 cm x 1 cm to the buttocks present on admission." 2/13/18 - WCD documented a sacral DTI 2.5 cm x 1.5 cm x 0 having necrotic skin. 2/18/18 - A weekly skin assessment documented a Stage 2 PU to the sacrum of R12. 2/18/18 - E17 (RN) wrote a physician's order for a wound treatment to R12, the order did not specify a location or frequency of the treatment. 2/24/18 - WCD documented a sacral DTI 4 cm x 5 cm x 0 having necrotic skin. February 2018 - Review of the CNA documentation for turning and repositioning each shift revealed 25 out of 28 dates from 2/1/18-2/28/18 that lacked documentation that R12 was turned each shift. February 2018- R12's TAR was absent documentation of dressing change completion for 2/27/18. 3/8/18 - A physician's "order clarification" was written for R12's sacrum to cleanse sacrum daily and PRN. March 2018 - Review of the CNA documentation	F 686		

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F 686	Continued From page 32 for turning and repositioning each shift revealed 8 out of 14 dates from 3/1/18-3/14/18 that lacked documentation that R12 was turned each shift. During an interview on 3/8/18 at 11:38 AM with E17 (RN) it was confirmed that she transcribed the treatment order for R12 written on 2/18/18 without a location or frequency. E17 then stated "It was written as a recommendation, we had an NP [unknown, no E#] here and she said "I don't know what the treatment should be, I haven't seen the patient" so I looked at the wound book at the nurses station and wrote a recommendation and left it out to be signed." E17 was unable to recall the name of the NP. During an interview on 3/8/18 at 12:21 PM with E22 (RN) it was confirmed that the Admission Braden Scale for R12 was completed 7 days late. During an interview on 3/9/18 at 1:28 PM with E3 (ADON) it was confirmed that a Braden Scale assessment for R12 should have been completed on admission. E3 then confirmed that the physicians order for treatment to R12's sacrum written on 3/8/18 was a clarification of the order written on 2/18/18 and stated that E17 "wrote it for every other day but it should have been daily." E3 confirmed variations in staging of R12's sacral wound on 2/13/18 as a DTI to 2/18/18 as a Stage 2 as incorrect and stated "we did a house sweep of assessments and started a new skin sheet but it [sacrum] was initially a DTI." E3 also reported that a pressure reducing mattress was not implemented for R12 until 3/8/18 and confirmed that R12's sacral wound worsened. During an interview on 3/9/18 at 1:36 PM with E3 (ADON) it was explained that the facility process	F 686		

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F 686	Continued From page 33 for obtaining treatment orders is to notify the physicians and obtain a telephone order to use the house wound protocol to be signed by the physician within that week. E3 stated that E17 (RN) "should have followed up with a supervisor or DON when unable to get the NP to authorize a treatment order for R12's sacral wound. E3 then confirmed that the physicians order written on 3/8/18 was a clarification of the order written on 2/18/18 and stated that E17 "wrote if for every other day but it should have been daily." R12 was admitted to the facility on 1/29/18 with redness to the buttock area that worsened to an unstageable PU. Review of the clinical record indicated that measures put in place to promote healing on the initial POS were not documented as completed by staff such as turning every two hours and an air mattress. A Physician's Order written on 2/18/18 for a treatment to R12's sacrum lacked location, frequency and was not signed by the physician in 18 days. On 3/8/18 the order was re-written for clarification. Review of wound care documentation revealed inconsistency with staging according to acceptable wound care guidelines for staging and descriptions. 3. Cross refer F600. Review of R11's clinical record revealed: 9/28/17 - Admitted to the facility with diagnoses including multiple sclerosis. 9/28/17 - Initial Nursing Assessment documented that she had no skin impairment, however, R11 had a bruise located in the right buttock. Initial nurse's note documented skin intact and small	F 686		

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F 686	Continued From page 34 discoloration (bruise) noted in upper right buttock. 9/28/17 - Admission orders included T & R every 2 hours every shift, house barrier lotion to perineal area each shift may keep at beside CNA may apply, weekly skin assessment, Braden Scale on admission and weekly for 4 weeks, Skin Prep no sting apply bilateral heels (no frequency). Record review lacked evidence of a Braden Scale upon R11's admission. 9/28/17 - A care plan for wounds and at risk for wounds, with initial date of 9/28/17, with most recent review date of 12/24/17, documented that R11 was at risk due to moisture from incontinence. Goal was that R11 would not develop a wound. Interventions included treatment as ordered, T & R every (frequency of this intervention was not documented), support surface to bed-Low air loss air mattress, support surface to chair-wheelchair cushion, and elevating of heels when in bed. Although the facility identified the need for T & R, the facility failed to have a system to identify the specific frequency for T & R to be performed by the staff, for a resident who was assessed as requiring extensive assistance of staff for bed mobility. Additionally, a weekly skin check was not included as an intervention. 9/28/17 - CNA "Maintenance ADL and Safety Care Plan and Communication Tool" (The facility's CNA care plan), documented T & R as needed and transfer with assistance of two staff. 10/5/17 - The Admission MDS assessment stated R11 was independent in daily decision making, required extensive assistance of two staff	F 686		

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F 686	Continued From page 35 persons for bed mobility, transfer, toileting. In addition, R11 had an indwelling suprapubic catheter and was always incontinent of bowel. The resident had no PU and was at risk for developing PU. Treatments included pressure reducing devices for chair and bed as well as application of medication or ointment. Intervention for a T & R program was left blank, thus, it could not be determined whether the facility identified the need for an individualized T & R program for R11. 10/9/17 through 11/20/17 - Weekly Skin Assessment, no new skin area of impairment. 12/24/17 - Braden score was 14, indicating moderate risk for the development of a PU. 12/27/17 - The Quarterly MDS assessment indicated that R11's condition remained unchanged with the exception that R11 now required increased assistance with transfer, from extensive to requiring total assistance. Although R11 was assessed as moderate risk on 12/24/17 and had a change in transfer, from assistance of staff to total assistance on the 12/27/17 MDS assessment, record review lacked evidence of a reassessment of interventions for prevention of PU. Record review lacked evidence of weekly skin assessment after 11/20/17 to 2/17/18, approximately three months. 2/1/18 through 2/17/18 (51 shifts) - CNA report documented the following: - Skin observation: 21 out of 42 shifts (2/1/18-2/14/18), lacked evidence this	F 686		

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F 686	Continued From page 36	F 686		

intervention was completed. From 2/15/18 through 2/17/18, there was no evidence that skin observation was completed during these three days.
- T & R: 28 out 51 shifts, there was lack of evidence R11 was T & R.
- Preventive Skin Care: 28 shifts out of 51, lacked evidence this intervention was provided.

2/7/18 - Physician's Order to have therapy evaluate R11, as R11 requesting new cushion for chair.

2/13/18 - Initial Occupational Therapy Evaluation, completed by E23 (OT), indicated reason for referral included decreased activity tolerance and risk for sacral excoriation and wheelchair positioning. R11 required total assistance for bed mobility and transfer. R11 sits in power wheelchair (PWC) with fair positioning but with frequent complaints of discomfort in hips. In addition, R11 verbalized the PWC was too small. The goal was for R11 to sit in PWC with good positioning with minimum reports of discomfort and with only occasional need for repositioning.

2/14/18 - OT Note by E23, documented the removal of a right lateral support and assisted nursing aid in positioning R11 in her PWC. Therapist assessed her response and R11 reported leaning to the left side. Therapist repositioned R11 and R11 reported increased comfort. Therapist educated R11 on communicating how the PWC feels with the new positioning.

2/15/18 - OT Note by E24 (OTA), documented R11 observed throughout day sitting in PWC. R11 did not complain of discomfort today and

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F 686	Continued From page 37 stated "fine today" which was not typical. R11 and E24 discussed positioning and comfort. R11 reported that her bottom hurts most of the time and that the PWC was too small. E24 advised current PWC was good fit and that the current cushion may need to be looked at. R11 reported she had experienced discomfort while sitting in the PWC many years ago and had mapping done in order to adjust the PWC. R11 was interested in having the mapping done again since it helped with comfort. R11 reported that the CNAs have been doing better with positioning in the PWC. 2/16/18 - OT Note by E25 (OTA) documented R11 reported discomfort with cushion today and feels that her chair is too small. E25's observation found chair was appropriate but R11 may benefit from a new cushion. COTA discussed this with E28 Director and OT for follow-up. 2/17/18 - OT Note by E23 documented that R11 was assessed for her comfort level seated in PWC and during mobility with PWC after therapist made adjustments removing the right lateral support. R11 reported she feels like she has more room and was more comfortable but was unhappy with her current cushion. Therapist informed R11 about assessing her cushion this week. 2/17/18 and timed 6:00 PM - Progress Note, by E14 (LPN) documented new PU of right inner buttock, described as an open wound measuring 1.0 cm X 0.8 cm with shallow, open wound bed with red/pink wound bed with no drainage. The wound was cleansed with normal saline and skin barrier applied. In addition, T & R was initiated.	F 686		

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F 686	Continued From page 38 2/17/18 - Weekly Pressure Ulcer Assessment documented a new stage 2 PU of right lower buttock was identified on 2/17/18 measuring 1 cm X 0.8 cm with no depth, no drainage. No signature of the staff who completed this assessment. Review of the facility's Treatment Guideline for Wound Care indicated for stage 2 PU, the treatment would include, cleansing area with normal saline (NSS), applying skin barrier wipe to periwound area, and apply hydrocolloid. Based on this protocol, the facility failed to follow the protocol by applying the skin barrier in the wound bed of the PU. Although R11 had a new PU of right buttock and R11 was unhappy with the current cushion, record review lack evidence that the facility identified the likely source of the pressure, which was likely from sitting in the PWC. This failure resulted in lack of reassessment of the interventions for pressure relief including the status of determining the need for a new PWC cushion. 2/18/18 - Order to cleanse left (incorrectly documented since the PU was on the right) buttock open area with NSS, pat dry apply Replicare daily and as need until healed. 2/19/18 - A clarification order to cleanse left (incorrectly documented again since PU was on the right) buttock open area with NSS, pat dry, apply Hydrogel, clean dressing daily until healed. 2/19/18 - OT Note by E23 documented R11 not getting up in PWC since she has a wound in her sacral area and when she was up in the PWC	F 686		

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F 686	Continued From page 39 yesterday, R11 stated that the Hoyer cushion was rubbing her sacral area and made it worse. 2/20/18 - Weekly Pressure Ulcer Assessment documented stage 2 PU of right lower buttock with measurements of 1 cm X 1.3 cm with no depth, no drainage. No changes in interventions were documented. 2/22/18 - OT Note by E25 documented R11 verbalized discomfort in chair in sacral area and R11 reported that she received present cushion in 2013 and was open to acquiring new cushion to help relieve discomfort. Discussed with E23 (OT) and E28 (DOR). Printed out information on cushion for R11 and gave it to E28 to pursue. 2/23/18 - OT Note by E23 documented E23 communicated with E28 (DOR) and therapy assistant as well as with nursing as there have been different concerns expressed by R11 related to positioning in the PWC. 2/24/18 - OT Note by E23. R11 reported that she was remaining in bed due to pain after dressing change to the wound. 2/26/18 - OT Note, E26 (COTA), R11 expressed how she has not been turned yet today at lunch time. E26 found a CNA to help E26 turn R11 to right side of the bed with maximum assistance of two with pillow for support to keep R11 off the sore in the sacral area to prevent further skin breakdown. 2/27/18 - Weekly Pressure Ulcer Assessment, stage 2 PU of right lower buttock measuring 4.1 cm X 3 cm with no depth, no drainage, pink/red with shiny, moist appearance, with no pain. It	F 686		

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F 686	Continued From page 40 was documented that the size of the wound worsened and T & R was one of the interventions. This assessment completed by E2 [DON]. Despite the fact that the PU worsened in size, record review lacked evidence of reassessment of the effectiveness of the interventions. 2/28/18 - OT Note, E23 documented communication with R11 about plan to improve her positioning. R11 has had a recent wound that was believed to be from sitting up in the WC with Hoyer pad. E23 discussed with E28 (DOR) who was on the wound care team and who had recommended two hours only in the PWC to ensure wound would heal. E28 to report this to nursing. E23 told the nurse on second shift that R11 had been up past two hours this day and nurse verbalized that she will ensure that R11 gets back into the bed. 2/28/18 - Order for R11 was only to be out of bed for two hours every day until wound was healed. Review of the care plan and CNA plan of care documentation, lacked evidence that the facility had a system to incorporate this new intervention. 3/2/18 - OT Note, by E26, R11 was able to tolerate up in PWC for 3 hours today. Although there was an order for only 2 hours per day in the PWC, the facility's system failed to ensure this order was carried out since R11 was documented to be in her PWC for 3 hours. 3/3/18 - OT Note, by E23. Communicated with R11 about time up in PWC and reducing risk of making her wound worse. E23 communicated	F 686		

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F 686	Continued From page 41 with CNA and assisted R11 in getting back to bed as well as positioning to stay to her left side to offload her sacral area to maintain skin integrity. 3/6/18 - Weekly Pressure Ulcer Assessment documented worsening of the PU. It was documented as a stage 2 of right lower buttock measuring 3.2 cm X 1.8 cm with no depth, no drainage, tissue type as slough, and no pain. Intervention of turning and repositioning was checked off. This assessment was completed by E6 (RN, UM). Record review lacked evidence that the facility identified that the PU was no longer a stage 2 due to presence of slough. This failure resulted in lack of reassessment of the interventions including treatment for the PU. 3/7/18 and timed 8:30 AM - Order indicated to discontinue current treatment to right buttock. New order to cleanse left (incorrect location) buttock with NSS, pat dry, apply Medihoney, cover with gauze daily and as needed until healed. 3/9/18 and timed 3:15 PM - Clarification order for treatment to be provided to right buttock and not to left buttock. 3/13/18 - Weekly Pressure Ulcer Assessment documented stage 2 of right lower buttock measuring 3 cm X 1.8 cm with no depth, purulent drainage, tissue type as slough, and no pain. No to the question, "worsening drainage" despite the drainage becoming purulent. This assessment completed by E3 [ADON]. 3/6/18 at approximately 3:16 PM - An interview	F 686		

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F 686	Continued From page 42	F 686		

with E6 (RN, UM North Unit) confirmed the care plan for wounds was not revised to include the actual PU of the right buttock. Additionally, the care plan failed to include the frequency of T & R as well as the need for weekly skin assessment. The CNA care plan also failed to include the frequency of T & R. When asked, what was the facility's system to update the care plan and the CNA care plan, E14 replied all licensed nurses are required to update the care plans. During the interview, it was unclear how E6 ensured provision of care and services, including the accuracy of the care plan and the CNA care plan.

3/8/18 at approximately 2:00 PM - An interview with E3 (ADON) revealed she led the facility's Wound Care Team which meets weekly on Tuesday. The team consisted of E3, E2 (DON), E28 (Director of Rehabilitation), and the Unit Manager. When asked if all interventions are reviewed and reassessed during weekly wound review, E3 was unable to provide surveyor a clear response. E3 was informed the care plan for wounds failed to include the actual PU of the right buttock as well as the T & R frequency. In addition, the CNA care plan lacked frequency of the T & R. E3 confirmed that the sling of the Hoyer lift did not cause the initial PU, however, the Wound Care Team determined that the sling caused the worsening of R11's PU. E3 confirmed that the low air loss mattress was obtained after the idenfication of the PU on 2/17/18.

3/9/18 at approximately 12:30 PM - An interview with E2 (DON) revealed that the facility ordered a new sling for the Hoyer lift since E2 related that the sling caused the worsening of R11's PU. E2 clarified that the Hoyer sling did not cause the initial PU of the right buttock. E2 confirmed the

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F 686	Continued From page 43 lack of weekly skin assessment, per facility policy. 3/13/18 at approximately 9:00 AM- An interview with E14 (LPN), the nurse who identified the new PU on 2/17/18 confirmed the skin barrier cream was applied directly to the PU since E14 mistakenly thought it was the skin barrier cream and not the skin barrier wipe. E14 additionally confirmed that although RN supervisor was notified, E14 does not recall whether the PU was assessed by the RN supervisor, however, E14 had completed the initial PU assessment. E14 related although he documented initiating the T & R every two hours, E14 was reinforcing the intervention already in place. When asked, what was the facility's system to update the care plan and the CNA care plan, E14 replied all licensed nurses are expected to do this. 3/13/18 at approximately 1:30 PM - An interview with E3 (ADON) confirmed that, despite weekly assessments documenting slough on 3/6/18 and 3/13/18, the staging of the PU remained at 2. E3 confirmed that the PU worsened with presence of slough but it was her understanding that one cannot change the stage of the PU. E3 related that she has not had any formal education on pressure ulcer prevention and management. 3/14/18 - OT Note, E23 documented R11 received a new PWC cushion. The new Vicair Cushion was rated for use with up to a stage 4 wound and R11 reported improved comfort. With this cushion, R11 was able to maintain position and equal distribution of weight while maintaining adequate positioning to access her environment. 3/15/18 - At approximately 2:00 PM, an interview with E23 (OT) revealed that the new cushion was	F 686		

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F 686	Continued From page 44 ordered approximately two weeks ago, after the new right buttock PU was identified and was placed in the PWC on 3/14/18. Despite that fact the facility identified on 2/16/18 that R11 may benefit from a new cushion, there was approximately one month delay in procuring a new pressure redistribution device for the PWC. The facility failed to have a system to: - Determine an individualized T & R schedule on 9/28/17 for a resident who required assistance with bed mobility. - Reassess interventions when R11's Braden score on 12/24/17 was documented as moderate risk. - Reassess interventions for transfer of R11 when decline was documented on the 12/27/17 MDS assessment. - Ensure timely identification for need of a new pressure redistribution device, a PWC cushion after the 2/7/18 order for therapy consultation. - Ensure facility's Wound Care Protocol was correctly administered when R11 had a new PU on 2/17/18. - Ensure a comprehensive initial assessment of the PU was completed by a Registered Nurse. - Reassess interventions when new PU of the right buttock was identified on 2/17/18. - Ensure timely procurement of a pressure redistribution device for R11's PWC. The cushion was placed in R11's PWC on 3/14/18, approximately 5 weeks after the initial order for therapy consult for new cushion. These failures resulted in worsening of PU from a stage 2 to PU with slough, likely a stage 3.	F 686		

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F 686	Continued From page 45 3/14/18 approximately 4:30 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E15 (RNC) and E16 (RVP). The facility failed to systematically ensure that residents received care, consistent with professional standards of practice, to prevent avoidable PUs. The facility failed to systematically ensure that residents received the necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new PUs from developing.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, it was determined that the facility failed to ensure that the resident environment remained as free of accident hazard as possible for one (R1) out of 15 sampled residents. Findings include: Review of R1's clinical record revealed: 8/20/15 - Care plan for fall/fall risk, with most recent revision date of 2/28/18 included an intervention for a fall mat to the left side of the	F 689	1. R#1 had the floor mat properly placed as indicated on the care plan upon discovery. 2. A root cause analysis was completed that revealed that the mat was not moved upon room transfer. For this reason, a review of all resident with fall mats was completed and adjustments made to the care plan and CNA Kardex as necessary. 3. The policy and procedure for room	5/14/18

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F 689	Continued From page 46 bed. 3/13/18 at approximately 9:40 AM - Observation revealed R1 in bed with eyes closed and no fall mat to the left side of the bed. Surveyor immediately notified the assigned licensed nurse, E14 (LPN) of the observation. 3/13/18 at 9:50 AM - Surveyor notified E2 (DON) of the above observation and E2 immediately informed E14 to secure the fall mat, which was located from R1's previous room, prior to the room change which occurred on 3/8/18. At 9:51 AM, the fall mat was placed at the bedside as care planned. 3/14/18 approximately 4:30 PM - Findings were reviewed with E1 (NHA), E2, E3 (ADON), E15 (RNC), and E16 (RVP). .	F 689	changes has been reviewed. Housekeeping and CNAs have been re-educated on how to perform proper room transfers. E14 has been re-educated on how to monitor that the interventions for falls are in place at all times. Nursing staff were re-educated on how to monitor that the interventions are in place upon transfer. Nursing unit managers monitor this expectation during their multi-shift rounds and by nursing supervisors on off shifts. 4. Audits will be completed as follows: a. Audits of 5 room transfers for fall risk interventions will be completed until 100% compliance is achieved. b. Then, room transfer completion and appropriate fall risk intervention application will be audited for every third room transfer. The Director of Nursing or Designee is responsible to ensure audits are completed as required.	
F 694 SS=D	Parenteral/IV Fluids CFR(s): 483.25(h) § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences.	F 694		5/14/18

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F 694	Continued From page 47 This REQUIREMENT is not met as evidenced by: Based on clinical record review and interview it was determined that the facility failed to ensure that care and services were provided for two (R6 and R14) out of 15 residents sampled who received parenteral fluids consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. Findings include: The facility's pharmacy policy and procedure titled "Central Vascular Access Device (CVADs), revised 5/1/15, states, "...1. Central vascular access devices (CVADs) include: 1.1 Peripherally Inserted Central Catheter (PICC)...6. Licensed nurses caring for patients receiving infusion therapies are expected to follow infection control and safety compliance procedures...4. Only preservative free normal saline for injection will be used for flushing a CVAD unless otherwise ordered by physician...". 1. Review of R6's clinical record revealed the following: 10/13/17 - R6 was admitted to the facility with diagnoses that included protein calorie malnutrition. !0/13/17 - Physician's admission orders stated R6 was to received TPN through a PICC line. Physician orders also stated the PICC line was to be flushed with NSS and Heparin (medication that keeps blood from clotting) after completion of the TPN.	F 694	1. R6 □ No longer resides in the facility. R14 □ No longer resides in the facility. 2. Residents receiving parenteral fluids have been reviewed for appropriate care and services including physician orders, care plan, observation of insertion site, and dressing change. The facility will perform this within professional standards and by following physician orders. 3. The facility completed the following review of systems and processes: a. Review of the facility pharmacy policy and procedure titled, Central Vascular Access Device (CVADs). b. Review of the facility policy and procedure titled,Central Vascular Access Device (CVAD) Dressing Change. Registered Nurses and LPNs who will manage Intravenous therapy have been recertified through an Intravenous (IV) Certification Program presented on-site by the facility's pharmacy provider. The certification program included, but was not limited to the following elements: i. Proper nursing protocol for IV flushing. ii. Proper dressing change procedures. iii. Proper documentation. A demonstration of competency will be performed when the facility admits another PICC line at the facility to validate	

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F 694	Continued From page 48 10/15/17 12:00 PM - The facility's Event Report stated that R6's PICC line was flushed with tap water after conclusion of the TPN infusion that day. 10/17/18 - A written statement, completed by E27[RN], stated, "...At 12 pm when the patient's feed was to stop and flushed (sic), machine beeping, I had to attend to one of the family members grievances, from there I went to room 600 to check on leaking g tube after which I went to (R6's) room...washed my hands and donned a glove, there were cups on resident's bedside table which she used for ice cubes. In one of the cups was water. This nurse mistakenly took the 10 ml NSS flush, squirted it out and took water from one cup @ the bedside and flushed the TPN line...I called the doctor on call and she ordered to send resident out for further evaluation...". Review of the clinical revealed that R6 was sent out to the ER and returned several hours later with no new orders and no evidence of any adverse effect. The facility failed to ensure that R6, who received parenteral fluids, specifically TPN via a PICC line, received care and services consistent with professional standards of practice and in accordance with physician orders. 3/13/18 approximately 4:30 PM - Findings were reviewed with E2 (DON), E3 (ADON), E15 (Regional Nurse Consultant) and E16 (Regional Vice President). 2. The facility's policy and procedure titled "Central Vascular Access Device (CVAD) Dressing Change," last revised 5/1/15, states	F 694	current practice of the nurses who will be caring for this resident. 4. Audits will be completed as follows: a. Daily audit will be completed of the care delivery and management of CVADs devices and dressing changes (when scheduled) until audits are 100% for three consecutive audits; then b. 3 times a week, until audits are 100% in compliance,for 3 consecutive audits; then c. Random audits of 25% of residents with CVADs, until 100%compliance x 3 months. d. Any trends will be brought to the QAPI meeting for review. The Director of Nursing or Designee will be responsible to ensure audits are completed as required.	

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F 694	Continued From page 49 "...1. Central vascular access devices (CVADs) include: 1.1 Peripherally Inserted Central Catheter (PICC) 2. The catheter insertion site is a potential entry site for bacteria that may cause a catheter-related infection...Guidance: 1. Sterile dressing change using transparent dressings is performed:...1.2 At least weekly...". Review of R14's clinical record revealed the following: 2/28/18 - R14 was admitted to the facility with a PICC line for administration of IV antibiotics. 2/28/18 - A physician's order sheet stated to change the catheter site dressing weekly and as needed with transparent dressing. 3/2/18 - Review of the Catheter Treatment Record revealed that the PICC line dressing site was due to be changed. Review of the Catheter Treatment Record and corresponding progress notes lacked evidence that the dressing was changed according to physician's orders. 3/8/18 - A care plan for Intravenous Therapy was developed and included the intervention "dressing change as ordered." The facility failed to ensure that R14, who received parenteral fluids via a PICC line, received care and services consistent with professional standards of practice and in accordance with physician orders. 3/14/18 approximately 4:30 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E15 (RNC) and E16 (RVP).	F 694		

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F 755	Continued From page 50	F 755		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on clinical record review and interview, it was determined that the facility failed to provide pharmaceutical services, including procedures	F 755	1. R15□s physician was notified of the medication omission. There were no other doses missed. R 15□s IV antibiotics have	5/14/18

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F 755	Continued From page 51 that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals, to meet the needs of one (R15) out of 15 sampled residents. Findings include: The facility's Pharmacy Products and Services Agreement, dated January 1, 2017, states "...AGREEMENT...1. RESPONSIBILITIES OF PHARMACY 1.1 General: During the term of this Agreement, Pharmacy shall: (a) provide Pharmacy Products to Facility and its residents in a prompt and timely manner in accordance with Applicable Law;...1.2 Delivery Schedule: Pharmacy shall deliver Pharmacy Products to Facility daily or as otherwise mutually agreed by the parties...1.3 Emergency Drug Service:...(b) Pharmacy shall provide any Pharmacy Product needed on an emergency basis as promptly as is reasonably practicable. In the event Pharmacy cannot furnish a Pharmacy Product ordered on an emergency basis in a reasonably prompt manner, Pharmacy shall use its best efforts to determine whether another pharmacy provider is capable of providing such Pharmacy Product to facility more promptly than Pharmacy...". Review of R15's clinical record revealed the following: 3/3/18 - R15 was re-admitted to the facility, post hospitalization, with a PICC line to be used for administration of the antibiotic Oxacillin every 4 hours for a bacterial infection in the resident's blood (bacteremia). 3/3/18 - A nurse's progress note, timed for the 7:00 AM to 3:00 PM shift, stated R15 arrived on the unit around 1:00 PM.	F 755	been discontinued as of 4/9. 2. The facility has adequate procedures for pharmaceutical services for ordering, dispensing and provision of all pharmaceutical services. All Residents receiving IV medications have had their medications checked to ensure appropriate supply is available. 3. Facility Management staff met with the pharmacy to address the issue and enhanced the Emergency Medication Kit (EMK) to increase IV medications stocked for emergencies and initial doses. Multiple doses of Oxacillin were added to the EMK and a number of available doses for all other medications in the box were increased. Hospitals have been requested to administer doses due prior to sending the resident to the facility. Facility personnel met with Chrisitiana Hospital case management and discharge coordination personnel on April 3, 2018 to discuss improved transfer planning. Nursing staff have been educated related to the changes made to the supply of medications in the EMK and actions to take when a medication is not available in the EMK including notification of the attending physician. Nursing administration will now verify that sufficient medications and supplies are available prior to admission to ensure that	

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F 755	Continued From page 52 3/3/18 - Review of the Central Vascular Access Device (CVAD) order sheet revealed R15 was to receive the antibiotic Oxacillin every 4 hours. The order sheet noted it was transcribed at 2:00 PM and the medication was requested from the pharmacy on 3/3/18 by 6:00 PM. 3/3/18 (time unreadable) - A nurse's progress note states, "...IV ABT (antibiotic) not available order obtain (sic) to start when IV ABT arrives...". 3/4/18 1:15 PM - A nurse's progress note states, "Resident missed 5 doses of her Oxacillin IV. Call placed to pharmacy. They could not explain delay...". 3/4/18 3:30 PM - A nurse's progress note states, "MD service made aware of the 5 missing doses. Gave new orders - 1. Change antibiotic Oxacillin IV time due to missed medication doses 2. May add the 5 missing dose (sic) of Oxacillin IV @ the end. Stopped (sic) date change from 4/9/18 to 4/10/18." Review of the Infusion Medication Administration Record revealed that R15 did not receive the first dose of IV Oxacillin until 3/4/18 at 10:00 AM, approximately 21 hours after being admitted to the facility. 3/13/14 approximately 4:30 PM - During an interview, E15 (Regional Nurse Consultant) stated that the pharmacy delivery times were: - Monday through Friday at 11 AM, 1:15 PM, 6 PM, and 8:30 PM; - Saturday at 11 AM and 5 PM; - Sunday at 1:15 PM; - STAT medications should be delivered within 2 hours.	F 755	medication is available in the facility. Nurses have been re-educated on the re-ordering process for medications and treatments and how to communicate to their supervisor if a needed medication is not available. They were also re-educated on the updated Emergency back-up medications available at the facility. 4. Audits will be completed daily to ensure the procurement and delivery of medications for resident admission and readmission according to physician orders until audits are 100% for three consecutive audits; then 3 times a week, until audits are 100% in compliance for 3 consecutive audits; then random audits of 25% of newly admitted or readmission residents, until 100% compliance x 3 months. Any trends will be brought to the QAPI meeting for review. The Director of Nursing or Designee will be responsible to ensure audits are completed as required.	

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F 755	Continued From page 53 The facility failed to ensure that pharmacy services were provided for R15 in a timely manner. R15 was admitted to the facility on 3/3/18 at approximately 1:00 PM. IV Oxacillin was not delivered until the following day, 21 hours later. 3/14/18 approximately 4:30 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E15 (RNC) and E16 (RVP).	F 755		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that one (R15) out of 15 sampled residents was free of any significant errors. Findings include: Review of R15's clinical record revealed the following: 3/3/18 - R15 was re-admitted to the facility, post hospitalization, with diagnoses that included atrial fibrillation (A fib/ abnormal heart rhythm). 3/3/18 - Review of the hospital discharge summary, which included a list of medications at discharge and any additional instructions, stated the resident needed close follow-up with INRs to adjust Coumadin dose accordingly, "INR 3.8 today, please hold Coumadin tonight, check INR tomorrow." The discharge orders were	F 760	1. R15□s PT/INR orders and Coumadin doses have been reviewed with the physician. 2. All current orders for Coumadin have been reviewed for proper transcription onto the MAR with the PT/INR book checked to assure appropriate tracking. 3. Root Cause Analysis revealed nursing staff did not follow the Coumadin protocol. Re-education has been provided with nurses on the current Coumadin protocol as follows: a. Coumadin orders are reviewed in the clinical daily meeting for completeness and implementation. b. Coumadin logs reviewed each day in	5/14/18

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F 760	Continued From page 54 transcribed onto facility records. 3/3/18 - Review of the MAR revealed that evenings dose of Coumadin was held according to physician's orders. 3/4/18 - Laboratory results revealed R15's INR was 1.36. A physician's order stated to give Coumadin 5 mg tonight and to check the INR tomorrow. 3/4/18 - The MAR and nurse's progress notes were reviewed and lacked evidence that the Coumadin 5 mg was administered as ordered. 3/5/18 - Laboratory results revealed R15's INR was 1.23. A physician's order to give Coumadin 5 mg tonight was written and for the INR to be checked tomorrow. 3/5/18 - The MAR revealed that Coumadin 5 mg was signed off as administered. 3/6/18 - Laboratory results revealed R15's INR was 1.43. The facility failed to ensure that R15 was free from significant medication error. 3/14/18 approximately 4:30 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E15 (RNC) and E16 (RVP).	F 760	clinical meeting and on the weekends by the nursing supervisor. c. Proper receipt, transcription and processing of physician□s' orders is completed with proper documentation. d. Labs are all reviewed in the clinical meeting and on weekends by the weekend supervisor for physician notification, and potential new Coumadin orders. Audits will be completed as follows: a. Daily audit of Coumadin and PT/INR records will be completed until audits are properly following our protocol for 100% compliance for three consecutive weekly audits; then b. 3 times a week, until audits are 100% in compliance for 3 consecutive weekly audits; then c. Random audits of 25% of residents on Coumadin until 100% compliance x 3 months. d. Any trends will be brought to the QAPI meeting for review. The Director of Nursing or Designee will be responsible to ensure audits are completed as required.	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public.	F 842		5/14/18

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F 842	Continued From page 55	F 842		

(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or

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F 842	Continued From page 56 unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on clinical record review and interview, it was determined that the facility failed to ensure, in accordance with accepted professional standards and practices that medical records for one (R14) out of 15 sampled residents are complete and accurately documented. Findings include: Review of R14's clinical record revealed the following: 2/28/18 - R14 was admitted to the facility for administration of an IV antibiotic Oxacillin. 2/28/18 - The physician's order sheet stated to	F 842	1. R14 no longer resides in the facility. 2. Root Cause Analysis revealed that nursing staff did not accurately document medications or treatments rendered in the clinical record. All current residents receiving IV medications were reviewed to ensure their Medication Administration Record (MAR) and Treatment Administration Record (TAR) had the appropriate documentation completed. 3. The following steps have been taken to	

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F 842	Continued From page 57 administer IV Oxacillin via a PICC line every 4 hours. The Infusion MAR revealed that the following doses of Oxacillin were not signed off as administered: - 3/8/18 at 10:00 PM; - 3/11/18 at 6:00 PM; - 3/12/18 at 6:00 PM and 10:00 PM. Review of corresponding nurse's progress notes for the above listed dates revealed documentation that medications were administered as ordered. 3/10/18 - The Catheter Treatment Record failed to be signed off signifying completion of a PICC site dressing change. 3/13/18 approximately 940 AM - Observation of R14's PICC site revealed a dressing dated 3/10/18. The facility failed to ensure, in accordance with accepted professional standards and practices that medical records for R14 were complete and accurately documented. 3/14/18 approximately 4:30 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E15 (RNC) and E16 (RVP).	F 842	ensure ongoing compliance: a. The Medication Administration Policy and Procedure was reviewed and no changes warranted. b. Nurses have been re-educated on proper completion of Medication Administration Records and Treatment Administration Records. c. Nurses have been re-educated on proper documentation related to IV site care. d. Nurses have completed an IV Certification Course provided through OmniCare Pharmacy. 4. Audits will be completed as follows: a. Daily until 100% compliance is achieved for 7 days; then b. 3 times per week to ensure that the Medication Administration Record and Treatment Administration Record is completed properly; until five consecutive audits are 100% compliant; then c. weekly until 3 consecutive audits are 100% in compliance; then d. Monthly audits of newly admitted or readmission residents,until 100% compliance x 3 months is achieved; and Any trends will be brought to the QAPI meeting for review. The Director of Nursing or designee is responsible to ensure compliance.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control	F 880		5/14/18

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F 880	Continued From page 58 The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism	F 880		

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	085039	A. BUILDING _____ B. WING _____	C 03/14/2018

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F 880	Continued From page 59 involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations and interviews it was determined that the facility failed to maintain an infection and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable disease and infections. Observations of R15 receiving care revealed facility staff failed to complete adequate hand hygiene on three (3) occasions and failed to dispose of used syringes in a safe and sanitary manner. Findings include: The Centers for Disease Control and Prevention	F 880	1. R#15 has been reassessed for infection. No adverse effects were identified. A wall sharps container was placed in the resident□s room. 2. All Residents are potentially at risk for infection due to lack of good hand hygiene. Resident□s rooms were assessed for presence of sharps containers. 3. Root Cause Analysis revealed staff did not demonstrate proper hand washing	

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F 880	Continued From page 60 (CDC) article titled "Clean Hands Count for Healthcare Providers states, "...Hand hygiene means cleaning your hands by using either handwashing (washing hands with soap and water)...antiseptic hand rub (i.e. alcohol-based hand sanitizer including foam or gel)...Clean your hands:...Before and after having direct contact with a patient's intact skin...After contact with blood, body fluids or excretions...After contact with inanimate objects (including medical equipment)...After glove removal...Techniques for Washing Hands with Soap and Water:..When cleaning your hands with soap and water, wet your hands first with water, apply the amount of product recommended...rub your hands together vigorously for at least 15 seconds, covering all surfaces...Other entities have recommended that cleaning your hands with soap and water should take around 20 seconds. Either time is acceptable...". (https://www.cdc.gov/handhygiene/providers/index.html) On 3/13/18, E18 (RN) was observed administering R15's IV antibiotic via a PICC line. The following was observed by two (2) surveyors: 12:00 PM - E18 brought the IV medication supplies into the room and proceeded to wash her hands with soap and water. E18 washed her hands for approximately 5 seconds, instead of the recommended 15-20 seconds, and then gloved both hands. E18 proceeded to pull a pen out of her pocket and write the time and date on the IV medication bag. Upon opening the IV tubing bag, E18 discovered that she had brought the wrong tubing. Since R15's lunch was delivered at this time, it was decided to wait until after R15 ate her lunch. E18 removed her gloves and left the room with the IV tubing and proceeded to the nurse's	F 880	technique and Sharps Containers were not available in every resident room. Wall sharps containers were placed in resident□s rooms if identified as absent. Staff have been re-educated on the Hand Hygiene policy. Nursing staff Hand Hygiene competency has been completed by return demonstration. 100% of resident rooms now contain sharps containers. Nurses have been educated on the use of the sharps container for both regular needles and needless system syringes. i. Nurses have participated in an IV Certification program presented by Omnicare. ii. Observations of hand hygiene now occurs daily by the Unit Managers and evening and weekend supervisors to validate proper hand washing. 4. Monitoring Audits will be completed as follows: a. Daily to ensure proper hand-washing and syringe disposal techniques until successfully demonstrated at 100% for 7 days; b. 3 times per week to ensure proper hand-washing and syringe disposal techniques until 100% compliant for 3 consecutive audits; then	

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F 880	Continued From page 61 station. 12:50 PM - Upon return to R15's room, E18 washed her hands with soap and water for 5 to 7 seconds, instead of the recommended 15-20 seconds. E18 then gloved and proceeded to perform a NSS flush (syringe filled with NS used to clear the IV line) of the PICC line prior to giving the IV antibiotic. E18 was observed drawing blood back into the syringe and then flushing it with the NSS. After the flush was completed, E18 discarded the syringe into a trash can next to the resident's bed. The IV antibiotic was then hung to be administered. E18 left the room and proceeded up the hall to the nurse's station. 1:27 PM - Upon return to R15's room, E18 washed her hands with soap and water for approximately 5 seconds, instead of the recommended 15-20 seconds, gloved, removed the IV tubing from the PICC line and proceeded to flush the line with one syringe filled with NSS and then a second syringe filled with a Heparin solution (keeps line from clotting off). Both syringes were discarded into a trash can next to R15's bed. E18 left the room with the IV antibiotic bag and tubing and discarded it in the trash container on the medication cart located midway down the hall then proceeded to the nurse's station. The facility failed to ensure completion of adequate hand hygiene on three (3) separate occasions and failed to dispose of used syringes in a safe and sanitary manner. 3/13/18 2:55 PM - Findings were reviewed with E18. E18 stated that she had used hand sanitizer when she arrived at the nurse's station after	F 880	c. Weekly until 3 consecutive audits are 100% in compliance; then d. Monthly until 3 consecutive audits are 100% compliant. Any trends will be brought to the QAPI meeting for review. The Director of Nursing or Designee will be responsible to ensure audits are completed as required.	

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F 880	Continued From page 62 leaving R15's room. 3/14/18 approximately 4:30 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E15 (RNC) and E16 (RVP).	F 880		
F 919 SS=L	Resident Call System CFR(s): 483.90(g)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area. §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to have an adequately equipped system to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area. The immediate jeopardy (IJ) was identified on 3/8/18 at 3:08 PM and abated on 3/8/18 at 6:30 PM. Findings include: 3/8/18 at approximately 1:00 PM - During an interview with E10 (DOM) , E10 stated upon his employment in April of 2014, he was informed by the previous DOM of a "dead spot" in the residents bathroom call bell reset switch. If the reset switch was not properly turned off and was set in the "dead spot" position, if another resident in the same room activated the bedside call bell, it deactivated the light in front of the resident's room and deactivated the centralized call box at	F 919	1. The following plan was implemented immediately to correct the call bell system: a. Every 15-minutes room checks to ensure resident□s needs were being met. (stopped 3/17/2018 as system was now operational) b. Every 4-hour shift supervisor room audits (stopped 3/17/2018) c. Every 4-hour administrative check to ensure the plan was being followed. (stopped 3/17/2018) d. Audit of all Residents in need of tap bells. All residents received a tap bell until call system was corrected (stopped 3/17/2018) The facility will provide an adequate system to allow residents to summon support of staff. All staff were educated on	5/14/18

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F 919	Continued From page 63 the nurses station, which indicated the room where the call bell was activated from the bed. Based on this situation, if this occurred, the staff would not know which resident(s) activated the call bell and the staff would have to go room to room to determine which resident(s) activated the call bell. 3/8/18 from approximately 1:10 PM to 1:25 PM - Three surveyors toured the building and checked the call system in room 100 and confirmed the presence of the same issue. 3/8/18 at approximately 2:00 PM - Interview with E10 revealed he had spoken with the manufacturer of the call system and there was no way to fix the problem with the switch. 3/8/18 at 3:08 PM - Interview with E1 (NHA) was conducted. E1 was advised of the malfunctioning switch and that it was an IJ citation. Findings were confirmed with E1. 3/8/18 approximately 6:15 PM to 6:30 PM - The facility provided a listing of all residents in the facility with their room numbers and identified those residents who were not capable of using a call bell. Observations were completed of every resident in the facility to verify that a manual call device had been provided for each resident capable of using it. Random residents interviewed expressed an understanding of the need of the alternate call device. Additionally, for all residents the facility instituted every 15 minutes staff observation and check to ensure residents needs were met. 3/14/18 approximately 4:30 PM - Findings were reviewed with E1, E2 (DON), E3 (ADON), E15	F 919	the call bell plan of correction, the availability of hand/tap bells and the process to follow should a malfunction occur. 2. Root Cause Analysis revealed that every resident bathroom call bell switch had a manufacturing flaw, that if not reset fully, would turn off the rooms' call function. 3. The manufacturer was contacted and did an onsite visit to assess the scope of the work needed to be done to correct the system. They were then contracted to change the call bell switch in every resident bathroom. Maintenance department verifies weekly that the call system is functioning. 4. Monitoring audits will be completed: a. Daily to ensure Call Bells are functional until audits are 100% for 7 days; b. 3 times a week to ensure call bells are functional until three consecutive audits are 100% compliant; then c. Weekly until 3 consecutive audits are 100% in compliance; then d. Monthly until 3 consecutive audits are 100% compliant. Any trends will be brought to the QAPI meeting for review.	

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F 919	Continued From page 64 (RNC) and E16 (RVP). New nurse call system switches were installed to permanently correct the malfunction on March 15, 2018 at 8:00PM..	F 919		

DELAWARE HEALTH
AND SOCIAL SERVICES
Division of Long Term Care
Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: New Castle Health and Rehab DATE SURVEY COMPLETED: March 14, 2018

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced complaint investigation survey was conducted at this facility from March 6, 2018 through March 14, 2018. The facility census on the first day was 107. The survey sample included 15 residents.		
3201 3201.1.0 3201.1.2	**Regulations for Skilled and Intermediate Care Facilities** **Scope** **Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross Refer to the CMS 2567-L survey completed March 14, 2018: F600 F610, F657, F658, F684, F686, F689, F694, F755, F760, F842, F880, and F919	Please cross refer to the survey completed March 14, 2018 and to the CMS 2567 Plan of Correction for: F600 F610, F657, F658, F684, F686, F689, F694, F755, F760, F842, F880, and F919.	May 14, 2018

Provider's Signature Richard Powell Title NHA Date 5/16/18